



# Maryland CANCER FUND

## Non-MHIP Application

**PLEASE COMPLETE ALL AREAS OF THE APPLICATION, Pages 1-3**

(If some areas do not apply, please mark “not applicable” or “N/A”)

### **Instructions:**

**PAGE 1:** **RESIDENCY ELIGIBILITY** – The patient must provide proof of Maryland residency for 6 months prior to the application date. **Please provide a copy of ONE of the following documents displaying patient’s name AND current home address:**

- Maryland Driver’s License
- Maryland State Identification Card
- Lease or Rental Agreement
- Property Tax Bill
- Motor Vehicle Registration
- Paycheck or Stub with Full Name and Home Address
- Utility Bill
- Voter Registration Card
- W-2 Statement (issued not more than 12 months ago)

**INSURANCE ELIGIBILITY** – The patient may not have any health insurance at the time of application and must remain uninsured during the time of service delivery.

**PAGE 2:** **ANNUAL FAMILY INCOME** – The patient must have an annual family income of not more than 250 percent of the federal poverty guidelines. Please list the total amount received from all sources of income before taxes are withheld.

### **FINANCIAL ELIGIBILITY**

**Please provide a copy of ONE of the following documents displaying patient’s name AND current home address:**

- **Most Recent Pay Stubs** – Must be for two pays in a row or two pays in the same month
- **Most recent income tax return**
- **Most recent W-2 form**
- **Social Security Entitlement Letter** – The Social Security Administration sends this by mail each January. It lists the amount the patient will receive each month.
- **Notarized Statement** – If the patient is not working, this statement should state that the patient is not working and does not have any income, or that the patient has not had any income in the past 6 months. This is a legal document and must be stamped and signed by a notary public. (See sample patient’s statement DHMH Form 4685).

**PAGE 3:** **PATIENT AGREEMENT** – Please read carefully because the application is a legal document. The patient’s signature indicates: (1) the statements that the patient made are true; (2) the MCF has the patient’s permission to verify the patient’s information provided; and (3) the organization applying on behalf of the patient has the patient’s permission to release information regarding the patient’s medical, financial, and insurance information to in the MCF.

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**INFORMATION CONTAINED IN THIS APPLICATION IS CONFIDENTIAL**

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**PATIENT INFORMATION** (Please type or print clearly)

Name: \_\_\_\_\_  
Last First MI

Date of Birth: //  
MM DD YYYY

Sex: ☐ Male  
☐ Female

Marital: ☐ Separated  
☐ Divorced  
☐ Married  
☐ Single/Never Married  
☐ Widowed

Ethnicity: ☐ Hispanic or Latino  
☐ Not Hispanic or Latino  
☐ Unknown

**Check all that apply:**

Race: ☐ White  
☐ Black or African American  
☐ Asian  
☐ American Indian or Alaska Native  
☐ Native Hawaiian or Other Pacific Islander  
☐ Other (Specify) \_\_\_\_\_

Patient Currently Employed: ☐ Yes ☐ No

If yes, place of employment: \_\_\_\_\_

If employed, how long? \_\_\_\_\_

Spouse Employed: ☐ Yes ☐ No

If yes, place of employment: \_\_\_\_\_

If employed, how long? \_\_\_\_\_

Home Address: \_\_\_\_\_  
Number, Street / P.O.Box

City/Town State Zip Code County of Residence

Maryland Resident: ☐ Yes ☐ No

Home Phone: /

Work Phone: / Ext:

Cell Phone: / E-Mail: \_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_ Phone: /  
Last First

Address: \_\_\_\_\_

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Child ☐ Other (Specify): \_\_\_\_\_

**Contact Person for Organization Applying:**

Name: \_\_\_\_\_ Phone: /  
First Last

**INSURANCE ELIGIBILITY**

Do you have any health insurance? ☐ Yes: ☐ No

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**ANNUAL FAMILY INCOME:** The total received per year from all sources of income before taxes are withheld.

|  | <b>INCOME</b><br>(Please indicate week, month or year) |  |                       |                                      | <b>FOR OFFICE USE ONLY<br/>DOCUMENTATION</b>  |
|--|--|--|-----------------------|--------------------------------------|---|
| <b>Patient Income</b><br>(Includes Social Security and any other retirement benefits)  | \$ .   | <input type="checkbox"/> Week<br><input type="checkbox"/> Month<br><input type="checkbox"/> Year | Yearly Total:<br>\$ . |                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A<br>Initial: _____ |
| <b>Spouse's Income</b><br>(Includes Social Security and any other retirement benefits)   | \$ .   | <input type="checkbox"/> Week<br><input type="checkbox"/> Month<br><input type="checkbox"/> Year | Yearly Total:<br>\$ . |                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A<br>Initial: _____ |
| <b>Parents' Income</b><br>(If patient is a dependent child on parents' income tax return)  | \$ .   | <input type="checkbox"/> Week<br><input type="checkbox"/> Month<br><input type="checkbox"/> Year | Yearly Total:<br>\$ . |                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A<br>Initial: _____ |
| <b>Child Support</b>   | \$ .   | <input type="checkbox"/> Week<br><input type="checkbox"/> Month<br><input type="checkbox"/> Year | Yearly Total:<br>\$ . |                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A<br>Initial: _____ |
| <b>Foster Child Supplement</b><br>(If child(ren) counted in household composition)   | \$ .   | <input type="checkbox"/> Week<br><input type="checkbox"/> Month<br><input type="checkbox"/> Year | Yearly Total:<br>\$ . |                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A<br>Initial: _____ |
| <b>Unemployment Insurance</b><br><input type="checkbox"/> patient <input type="checkbox"/> spouse <input type="checkbox"/> parent  | \$ .   | <input type="checkbox"/> Week<br><input type="checkbox"/> Month<br><input type="checkbox"/> Year | Yearly Total:<br>\$ . | Start Date: _____<br>End Date: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A<br>Initial: _____ |
| <b>Workman's Compensation</b><br><input type="checkbox"/> patient <input type="checkbox"/> spouse <input type="checkbox"/> parent  | \$ .   | <input type="checkbox"/> Week<br><input type="checkbox"/> Month<br><input type="checkbox"/> Year | Yearly Total:<br>\$ . | Start Date: _____<br>End Date: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A<br>Initial: _____ |
| <b>Social Security Disability Insurance</b> <input type="checkbox"/> dependent child<br><input type="checkbox"/> patient <input type="checkbox"/> spouse <input type="checkbox"/> parent | \$ .   | <input type="checkbox"/> Week<br><input type="checkbox"/> Month<br><input type="checkbox"/> Year | Yearly Total:<br>\$ . |                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A<br>Initial: _____ |
| <b>Alimony</b><br><input type="checkbox"/> patient <input type="checkbox"/> spouse <input type="checkbox"/> parent   | \$ .   | <input type="checkbox"/> Week<br><input type="checkbox"/> Month<br><input type="checkbox"/> Year | Yearly Total:<br>\$ . |                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A<br>Initial: _____ |
| <b>TOTAL ANNUAL FAMILY INCOME</b>  |  |  | \$ .                  |                                      |   |

### FINANCIAL ELIGIBILITY

To determine your financial eligibility for this program, we need to collect information regarding household composition and family-income. **PROOF OF INCOME MUST BE ATTACHED – (Your most recent Income Tax Return is preferred.** Otherwise, provide your W-2 Forms, Social Security Entitlement Letter, a minimum of 2 pay stubs in a row or 2 pays in the same month, or a notarized letter stating “No Income and No Employment” can be substituted).

### FAMILY COMPOSITION

Please list the names and ages of all family members within the household and indicate their relationship to the patient. Include: patient, spouse, financially dependent child(ren) and all other dependents listed on your income tax return form. If the patient is a child, include: child, parent, foster parent, or guardian, sibling(s).

| LAST NAME | FIRST NAME | AGE | RELATIONSHIP TO PATIENT |
|-----------|------------|-----|-------------------------|
| 1.        |            |     |                         |
| 2.        |            |     |                         |
| 3.        |            |     |                         |
| 4.        |            |     |                         |
| 5.        |            |     |                         |

**If there are more than five (5) family members within the household, please continue the list on a separate sheet and attach.**

**Total number of people in family, including patint:**

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**PATIENT AGREEMENT**  
*(Please read carefully before signing)*

I certify that all the information on this form is true, correct and complete. I understand that any false statements would subject me to penalties under State law and would result in a denial of grant eligibility.

I authorize the Maryland Department of Health and Mental Hygiene, Center for Cancer Surveillance and Control, Maryland Cancer Fund (MCF) to verify any information provided by me on this form. I will provide proof of any information on this form as required by the MCF.

I agree to allow the \_\_\_\_\_  
Name of Organization

to release the medical/financial/insurance information regarding my cancer treatment and the Maryland Department of Health and Mental Hygiene that administers the Maryland Cancer Fund.

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Name of Contact Person for Organization Applying  
(Please Print or Type)

\_\_\_\_\_  
Name of Patient  
(Please Print or Type)

\_\_\_\_\_  
Address of Contact Person  
(Please Print or Type)

\_\_\_\_\_  
Date of Application

\_\_\_\_\_  
Office Phone of Contact Person

**RETURN COMPLETED MCF APPLICATION TO:**

**Maryland Cancer Fund  
Maryland Department of Health and Mental Hygiene  
201 West Preston Street, Room 306  
Baltimore, Maryland 21201**

**For questions, please call (410) 767-6213**

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